Emergency Form for Extended Day Program (EDP)

Child's Name: _____
LAST FIRST

Address:_____

_____

Home Phone Number: _____

Father's Full Name: _____

Work Phone Number: _____Cell Phone Number: _____

Mother's Full Name: _____

Work Phone Number: _____Cell Phone Number: _____

Student(s) live with: Parents _____Mother_____Father_____Other_____

School Insurance: YES _____ NO _____ If No, list Company _____

St. Zachary Extended Day Program
Emergency Treatment Release

To Whom It May Concern:

As a parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after reasonable effort has been made to reach me. Necessary first aid may be given at school.

Name of Minor: _____Relationship:_____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signed: _____

Father: _____Mother:_____Legal Guardian_____

Address: _____

Home Phone: _____

Hospital Preference:_____

Family Physician: _____

Specify Medical allergies, chronic illnesses or other conditions: _____

Please notify the School Office with any changes to the above information.

Please complete both sides of this form and return to the school office.